Request to Amend Protected Health Information

THIS FORM WILL ALLOW ME TO REQUEST AN AMENDMENT OF MY PROTECTED HEALTH INFORMATION (PHI) THAT CIGNA HEALTHCARE®* MAINTAINS.

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items.)

Name of Customer: _____ Date of Birth: _____

Phone number where we can reach you if we need to contact you to process your request (required): _____

Social Security # (Optional): _____ Group or Account # on ID card: _____

Customer ID card # (if applicable): _____ Subscriber Name (if different from Customer): _____

Subscriber's Relationship to Customer: _____ Subscriber's Employer Name: _____

Subscriber's Social Security # (if different from Customer) (Optional): _____

If you have additional coverage with CIGNA, other than described above, please complete the following information as well:

Other Employer Name: _____

Customer ID card #: _____ Group or Account # on ID card: _____

INFORMATION REQUESTED TO BE AMENDED

If CIGNA HealthCare was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. For example, this would apply to your diagnosis, the date of service, or the treatment received. If the provider consents to amend your information and notifies CIGNA HealthCare, we will change the information in our records. In that case, it would not be necessary to submit this form.

If CIGNA HealthCare approves your request to amend, the amended information will be used and included in all future disclosures, including correspondence. We will provide the amendment to persons who previously received the information if we believe they have relied or will rely on that information to your detriment. Also, we will provide the amendment to individuals/organizations you identify below.

Names/addresses of individuals/organizations to whom you request amended information be sent, if request is approved:

_____

_____

_____

Describe the Protected Health Information (PHI) you would like amended: _____

_____

_____

Specify change/amendment requested: _____

_____

_____

Date(s) of service associated with the PHI, if applicable: _____

Reason for requested amendment: _____

_____

_____

_____

Please Complete Form On Next Page ➥

PLEASE NOTE

- *This amendment of your protected information* ***only includes information that CIGNA HealthCare and its affiliates maintains****. It does not include information that may be maintained by the subscriber's employer/group health plan, their business associates, or other insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.*
- *If the information on this form is not complete, CIGNA HealthCare will return the form to you, and this request will not be considered until CIGNA HealthCare has received complete information.*

SIGNATURE

I have read and understand the above information:

Date: _____ Signature of Customer, Parent/Guardian, Personal Representative: _____

_____

Relationship if signed by other than Customer: _____

_____

Note that if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If Customer is unable to give consent because of age, complete the following: Customer is a minor _____ years of age.
If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please Return This Completed Form To:

CIGNA HEALTHCARE • CENTRAL HIPAA UNIT • PO Box 188014 • Chattanooga, TN 37422